(6) Home health care services;

(7) Outpatient prescription drugs;

(8) Services of health maintenance organizations and health insuring organizations;

(9) Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;

(10) Dental services;

(11) Podiatric services;

(12) Chiropractic services;

(13) Optometric/optician services;

(14) Psychological services;

(15) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;

(16) Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;

(17) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;

(18) Emergency ambulance services; and

(19) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

(i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;

(ii) The payer of the fee cannot be held harmless; and

(iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

(b) Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993]

§ 433.57 General rules regarding revenues from provider-related donations and health care-related taxes.

Effective January 1, 1992, CMS will deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not—

(a) Donations and taxes that meet the requirements specified in § 433.58, except for certain revenue received during a specified transition period;

(b) Permissible provider-related donations, as specified in § 433.66(b); or

(c) Health care-related taxes, as specified in § 433.68(b).

§ 433.58 Provider-related donations and health care-related taxes during a State's transition period.

(a) *General rule.* During the State's transition period specified in paragraph (b) of this section, a State may receive certain provider-related donations and health care-related taxes without a reduction in FFP. These provider-related donations and health care-related taxes must meet the conditions specified in this section and are subject to limitations specified in § 433.60.

(b) *Transition periods for States.* (1) Except as provided in paragraph (b)(2) of this section, the provisions of this section apply for the period beginning January 1, 1992 and ending—

(i) September 30, 1992, for States whose State fiscal year begins on or before July 1, 1992; or

(ii) December 31, 1992, for States whose State fiscal year begins after July 1, 1992.

(2) The provisions of this section apply for the period beginning January 1, 1992 and ending June 30, 1993 for States that—

(i) Are not scheduled to have a regular legislative session in calendar year 1992;

(ii) Are not scheduled to have a regular legislative session in calendar year 1993; or

(iii) Had enacted a health care-related tax program on November 4, 1991.

(c) *Provider-related donations during the transition period.* Subject to the limitations specified in § 433.60, a State may receive, without a reduction in FFP, provider-related donations described in paragraph (d)(3) of this section during the applicable transition period.

(d) *Permissible donations.* To be permissible donations, the donations must be—

(1) Bona fide donations, as defined in § 433.54;

(2) Donations made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at that facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid and/or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. Direct costs of outstationed eligibility workers refers to the costs of training, salaries and fringe benefits associated with each outstationed worker and similar allocated costs of State or local agency support staff, and a prorated cost of outreach activities applicable to the outstationed workers at these sites. The prorated costs of outreach activities will be calculated taking the percent of State outstationed eligibility workers at a facility to total outstationed eligibility workers in the State, and multiplying the percent by the total cost of outreach activities in the State. Costs for such items as State agency overhead and provider office space are not allowable for this purpose; or

(3) Provider-related donations, even if the donations do not qualify under the provisions of paragraph (d) (1) or (2) of this section, that meet the following conditions:

(i) The donation program was in effect on September 30, 1991, described in State plan amendments or related documents submitted to CMS by that date, or substantiated by written documentary evidence (as described in paragraph (e) of this section) that was in existence as of that date; and

(ii) The donation program is applicable to the State's fiscal year 1992, as demonstrated by written documentary evidence as described in paragraph (e) of this section.

(e) *Written documentary evidence.* The State must have written documentation, which was in existence on September 30, 1991, of a donation program described in paragraph (d)(3) of this section that includes the dollar amounts it received in State fiscal year 1992 and the amounts it intended to receive, as evidenced by one or more of the following:

(1) Reference to a donation program in a State plan amendment or related documents, including a satisfactory response, as determined by CMS, to a CMS request for additional information;

(2) State budget documents identifying the amounts States expected to be received in donations;

(3) Written agreements with the parties donating the funds; and/or

(4) Other written documents that identify amounts that the States planned to receive in donations from specified organizations during that period.

(f) *Application of rules to State fiscal year 1993.* For any portion of a State's fiscal year 1993 that occurs during the transition period, the State may receive, without a reduction in FFP, the amount of provider-related donations that it received in the corresponding period in State fiscal year 1992, including the 5 days after the end of that period, subject to the limitations specified in § 433.60(a).

(g) *Health care-related taxes during the transition period.* (1) Subject to the limitations specified in § 433.60, States may receive, without a reduction in FFP, health care-related taxes during the State's transition period if:

(i) The health care-related taxes are broad-based and uniformly imposed, and the taxpayer will not be held harmless, as specified in § 433.68; or

(ii) The health care-related taxes are imposed under—

(A) A tax program that was in effect as of November 22, 1991; or

(B) Legislation or regulations that were enacted or adopted as of November 22, 1991.

(2) A State may not modify health care-related taxes in existence as of

November 22, 1991, without a reduction of FFP, unless the modification only—

(i) Extends a tax program that was scheduled to expire before the end of the State's transition period;

(ii) Makes technical changes that do not alter the rate of the tax or the base of the tax (for example, the providers on which the tax is imposed) and do not otherwise increase the proceeds of the tax;

(iii) Decreases the rate of the tax, without altering the base of the tax; or

(iv) Modifies the tax program to bring it into compliance with § 433.68(f).

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993, as amended at 58 FR 43180, Aug. 13, 1993]

§ 433.60 Limitations on level of FFP in State expenditures from provider-related donations and health care-related taxes during the transition period.

(a) *Maximum amounts.* The maximum amount of total provider-related donations, as specified in § 433.58(d)(3), and health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year in the State's transition period specified in § 433.58(b) is calculated by multiplying—

(1) The State's total medical assistance expenditures for the fiscal year; by

(2) The greater of:

(i) 25 percent; or

(ii) The ''State base percentage'' (as described in paragraph (b) of this section).

(b) *State base percentage.* (1) The State's base percentage is calculated by dividing the amount of the provider-related donations and health care-related taxes identified in § 433.58 and estimated by CMS to be received in the State's fiscal year 1992 by the total non-Federal share of medical assistance expenditures (including administrative costs) in that fiscal year based on the best available CMS data.

(2) In calculating the amount of taxes specified in paragraph (b)(1) of this section, taxes (including the tax rate or base) that were not in effect for the entire State fiscal year, but for which legislation or regulations imposing such taxes were enacted or adopted as of November 22, 1991, will be estimated as if they were in effect for the entire fiscal year.

(c) *Deductions before calculating FFP.* Before calculating FFP, CMS will deduct from a State's medical assistance expenditures the total amount of any provider-related donations described in § 433.58(d)(3), and health care-related taxes in excess of the limit calculated under paragraph (a) of this section.

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993]

§ 433.66 Permissible provider-related donations after the transition period.

(a) *General rule.* (1) Except as specified in paragraph (a)(2) of this section, subsequent to the end of a State's transition period, as defined in § 433.58(b), a State may receive revenues from provider-related donations without a reduction in FFP, only in accordance with the requirements of this section.

(2) The provisions of this section relating to provider-related donations for outstationed eligibility workers are effective on October 1, 1992, whether or not the State's transition period continues beyond that date.

(b) *Permissible donations.* Subject to the limitations specified in § 433.67, a State may receive, without a reduction in FFP, provider-related donations that meet at least one of the following requirements:

(1) The donations must be bona fide donations, as defined in § 433.54; or

(2) The donations are made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at the facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. Direct costs of outstationed eligibility workers refers to the costs of training, salaries and fringe benefits associated with each outstationed worker and similar allocated costs of State or local agency support staff, and a prorated cost of outreach activities applicable to the outstationed workers at these sites. The prorated costs of outreach activities will be calculated taking the